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FEATURE ARTICLE	2	RESEARCH RESOURCE	11
Kunde Hospital: Nepal		The Bombay University Library	
WORK IN PROGRESS	4	RESEARCH REPORT	13
Public Health in Ceylon		India and the USA: A researcher's reflections	
Medical research in western India		BOOK REVIEWS	15
Buddhist medicine in Angkor		RESEARCH GROUP NEWS	20
CONFERENCE REPORTS	8	London, Birmingham, Manchester	
NEW PUBLICATION	9	CALENDAR	24



Kunde Hospital

Sir Edmund Hillary and the Sherpa of the Mt Everest area of Nepal

In 1966, New Zealander Sir Edmund Hillary, who with Tenzing Norgay had first stood on the summit of the world's highest mountain in 1953, built a small hospital in the Sherpa village of Kunde at the foot of the region's sacred mountain, *Khumbu-yul-lha*.

Surrounded by the snowy peaks of this rugged, high-altitude region the hospital was part of Hillary's wider aid programme to assist the people of the Mt Everest area in Nepal who have played such an important role in Himalayan mountaineering. It was set up to provide Western medical services which it has done, but it had to learn how to function among people who did not believe that Western medicine was inherently superior to other systems of beliefs and practices.

The Sherpa of Khumbu are an ethnically Tibetan people who came over the mountain passes of the Himalaya in the early 16th century into what was then an uninhabited area. In the 18th century the region became incorporated into the Gorkha kingdom that now forms the modern nation of Nepal. The new rulers were Hindu while the Sherpa, like a number of small groups living along the Himalaya, were Buddhist. Both the geographic location of the Sherpa near Nepal's border and their low position in the Nepali social and political structure contributed to them largely being left alone, apart from the payment of taxes. Sherpa lived in villages and generally managed their own affairs, with their livelihood based on a mixture of agriculture and pastoralism, and supplemented by trade as the area was located on a long-distance trade route between northern India and China.

Although Nepal's borders were generally closed to Western visitors until 1949, Western medicine had had a limited presence within the country since the 18th century. In the late 19th and early 20th centuries hospital services expanded, as in other countries, and in 1933 the government's newly formed Department of Health Services promoted both Western and Ayurvedic medicine. During the 1950s further expansion occurred, particularly with the increasing presence of foreign aid, but in the early 1960s services were still very limited, or non-existent, in rural areas where most people lived. Many people in remote Khumbu would only have heard of the type of medicine offered by Kunde Hospital, although some, particularly those people employed by the mountaineering expeditions, may have used it.

Western medical practice did not enter a vacuum, but Sherpa beliefs and practices about sickness revolved around a different system to that of the New Zealand volunteers brought in to run the hospital. Sherpa inhabited a world that was full of various types of beings that could be dangerous if offended or ignored, but could also be appeased through appropriate measures. Sherpa could employ a number of strategies to deal with sickness, including prevention, self-help or consulting a *lama* or *lhawa* (spirit medium). Finding out the cause took precedence over dealing with the symptoms, although the perceived severity could influence whether or not the patient or family sought assistance. People made a preliminary decision on which to call, but when a person was very sick they often used both.

Early documents reveal the complexity of the encounter between Sherpa beliefs and practices, and those of Western medicine.

Cover and
above:

Mount Everest.
Image courtesy
of author

Sherpa also had another option – the use of an *amchi*, the practitioner of Tibetan medicine. Oral sources indicate that prior to 1950 Khumbu did not have its own *amchi*. Sherpa recognised *amchi* medical practice as different, but because of their shared Tibetan origin not as different as Western medicine.

Kunde Hospital has been the major provider of biomedical services in the area since its opening. It has been run by the Himalayan Trust in New Zealand, which Hillary established to run a large number of education, health, forestry and community projects that since their inception in the early 1960s have had an enormous impact on the region and its people. Today this small hospital offers a range of mainly primary and some secondary services to about 3500 people in the immediate locality of Khumbu and a similar number from adjacent districts, as well as being available to tourists when they are sick.

The hospital has become part of the global fascination with the area and its people. Many people have been treated as out-patients. Rising numbers from 1924 during 1967 to 7224 in 1996, without a corresponding rise in the resident population, show increasing use being made of the hospital. It also provided in-patient facilities for serious cases or for people who lived a long distance from the hospital. The area has no roads and some patients may walk, or are carried, for several days to reach Kunde. Early documents reveal the complexity of the encounter between Sherpa beliefs and practices, and those of Western medicine; the uncertainty of the volunteer doctors at Kunde Hospital as to the outcome, and the importance of proving the efficacy of Western medical treatment. People were both pragmatic and selective in their use. They were keen, for example, to have smallpox vaccinations, but less enthusiastic about other prophylactic measures.

Reviewing Kunde Hospital's first nine months of operation, John McKinnon, the first doctor, wrote of the mixed response to 'modern medicine', but thought: "The passage of several years, with exposure to modern medical practice and local publication of therapeutic successes, will lead to even greater acceptance." He believed three main successes gave positive initial publicity for the hospital: the decrease in the size of the goitres as a result of iodized oil injections; the treatment of tuberculosis which was widespread with high mortality rates; and the freedom from years of pain with the extraction of rotten teeth.

Five years later Dr Lindsay Strang wrote in his annual report that "Western medicine continues to be accepted only slowly and still traditional forms are often resorted to initially especially for serious conditions." Dr Selwyn Lang had written around 1970–71 how he and his wife Ann, also a doctor, "have ligated a spurting artery at one end of the patient while the spirit medium sprinkled water on the other". Already the overseas staff were becoming used to offering Western medicine in a setting where its anticipated inherent supremacy was not accepted and advice and treatment often ignored. The use of biomedical services did increase, but within a plural system.

Persuading patients to return for follow-up monitoring or treatment was a recurrent problem. For example, the length of treatment for TB – despite now being much shorter – was a constant frustration for hospital staff. Annual reports frequently noted patient refusal. Attempts were made to encourage attendance or treatment compliance through highlighting cases of cured individuals, health education talks, or enlisting the support of the Hospital Advisory Committee or the local district committee.

Staff were becoming used to offering Western medicine in a setting where its anticipated inherent supremacy was not accepted.

Obstetrics was another area where the hospital has met resistance. The Langs reported in an analysis of the first five years of the hospital's work that of 74 women who came in for antenatal care only nine were subsequently delivered by the doctor.

While part of understanding the nature of medical practice at Kunde Hospital lies in the medical encounter, part also relates to the wider relationship between the hospital and the community. The community has had considerable influence on the way Western medicine has been practised or offered from Kunde Hospital. Kunde Hospital did not exist in isolation; it was part of the wider Himalayan Trust programme with its philosophy of working with and respecting the local people. Hospital staff, local and overseas, learned how to respond to the way people regarded their services and often had to adapt their practice accordingly.

After 37 years hospital and community have become used to each other. The local hospital staff, who are mostly Sherpa, have played a key role in 'educating' both the volunteers about living and working in Sherpa society and the patients about being at the hospital. The small number of staff know the community well, and while the overseas volunteers changed generally every two years, there has been considerable local staff stability since 1980.

The history of Kunde Hospital, therefore, allows us to examine the spread of Western medicine into the Everest region of the Himalaya of Nepal providing both comparison and contrast with other areas. Its relatively recent history with available archival and oral sources also allows a closer look at the encounter between local beliefs and practices and incoming Western medical services. With international medical aid programmes providing such a major role in health in many countries the close relationship between Kunde Hospital, Sir Edmund Hillary and the Sherpa people of the Mt Everest area of Nepal offers some pertinent thoughts for those involved with aid in the Third World.

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Public health in Britain's model colony of Ceylon

MARGARET JONES

The role of Western medicine in colonial societies has been the subject of a vigorous historiographical debate. Viewed at the time as one of the positive benefits of colonialism, it is now frequently seen as a key aspect of its oppression.

My recently published book provides a case study for exploring these controversies in relation to colonial Sri Lanka. It was called a model colony in the 19th century because it set the pattern for crown colony governance. Again, in the 20th century, somewhat ironically given the current tensions in the island, it provided a model for a relatively conflict-free process of decolonisation with the granting of independence in 1948.

With regard to health policy, colonial Sri Lanka is particularly interesting for three reasons. First, for nearly two decades preceding independence the colony was virtually self-governing. The legislature, the State Council, was elected on universal suffrage and the executive, the Board of Ministers, was chosen from these elected representatives. Although the imperial government kept some reserve powers, policy making was essentially in the hands of indigenous politicians. Responsibility for the direction and implementation of health policy therefore lay with an elected Ceylonese Minister of Health. It was generally accepted by contemporaries and by historians that this elected government paid much more attention to questions of health and welfare than previous colonial governments.

The second important feature is that the colonial medical service was composed mainly of indigenous practitioners, products of the colony's medical school established in 1870. It was Ceylonese doctors who ran and staffed the colony's hospitals, the preventive medical and public health facilities. The Ceylonisation of the medical service was completed in 1936 when a Sinhalese, S T Gunasekera, became the first non-British Director of the Medical and Sanitary Services.

Thirdly, the record of Sri Lanka (a relatively poor country) in quality of life indicators, such as infant and maternal mortality and life expectancy is exemplary and requires some explanation. It has been argued that this is partly due to the embryonic welfare state which was in place by 1948, one of the pillars of which was the colonial healthcare system. Does this case study provide evidence that on balance Western medicine in the colonial context was beneficial?

My book argues that the record of the colonial government's health policy is in fact a mixed one. Before 1948 Ceylon's epidemiological profile never made the transition to a modern one. Communicable diseases remained the principal causes of death. Deaths from dysentery, diarrhoea and respiratory diseases continued at a high level. Pure water supplies and water-borne sewage disposal were not supplied, and a safe urban environment not ensured. The reasons for these failures are explored fully in the book and attributed, among other factors, to the reluctance of the imperial and colonial governments as well as the ratepayers to accept the necessary financial responsibility. Malaria and ankylostomiasis continued to debilitate the population. The 1934–35 malaria epidemic, which claimed the lives of nearly 100 000 people, is testament to the failure to control the ravages of such communicable diseases.

Alongside these failures, however, there were unquestioned successes. Infant and maternal mortality had declined by 1948 and even malaria was being brought under control, if only temporarily. These achievements can be attributed in part to the adoption of preventive healthcare services which by 1948 covered the whole island. These included infant and maternal welfare services, a health unit system whose primary function was to provide preventive healthcare services, school medical inspection and treatment, and free school meals after 1935. There was also an extensive island-wide hospital system staffed by indigenous doctors. After 1941 the government also supported the indigenous system of medicine. An Ayurvedic training college, hospital and dispensaries were funded by central and local governments.

How does the example of Ceylon contribute to the debates about colonial medicine? If it is accepted that good health is a necessary basis for the wellbeing of individuals then

Opposite above:

Jones's book argues that the record of the colonial government's health policy was mixed.

Right:

The colonial medical service in Ceylon was composed mainly of indigenous practitioners.



real improvements in health, as seen in Ceylon, must be acknowledged as a positive gain.

This does not necessarily rebut the charge that the colonial medical services were a tool of imperialism. They could indeed be oppressive. But at the same time they could also be beneficial for indigenous populations.

Furthermore, there is a very real conflict in any society between the needs of the community, as defined by the government, and the freedom of the individual in collective public health provision. The imposition of such measures on colonial populations where consent was at best dubious does bring this dilemma into sharp relief. But was the imposition any greater, say, than on working class men and women in Britain? Moreover, in Ceylon the indigenous population was able to contest and negotiate their relationship with the medicine of their colonial rulers. The government's support of Ayurveda is just one illustration of this. It could be argued that the situation in Ceylon was unique within the imperial system, but its health record does reinforce what is increasingly apparent in recent literature on the subject that simplistic generalisations are suspect. The impact and legacies of colonial medicine, as indicated in the experience of Ceylon, are both contradictory and variable.



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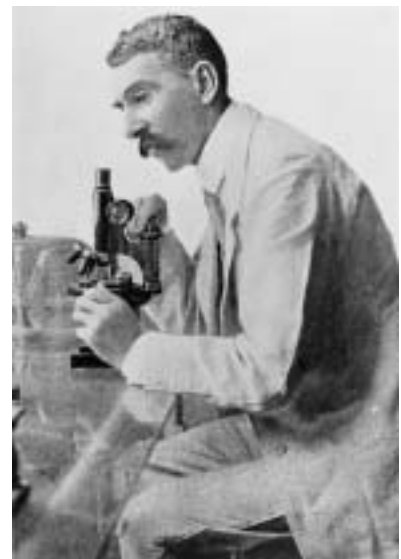
State policy, philanthropy, and medical research in western India, 1898–1962

SHIRISH KAVADI

India, as British and Indian medical circles noted, was “the largest disease laboratory in the British Empire” offering large opportunities for “scientific exploitation”.

Yet the British Indian Government appears to have done little to encourage medical research apart from setting up bacteriological laboratories, which became “mere bottling centres for standard vaccines and sera”. The research structure that evolved, R Ramasubban observes, was shaped by piecemeal and *ad hoc* response to sudden epidemic outbursts. Studies conducted by the All India Institute of Medical Sciences in 1991 and 1996 conclude that India lacks a strong medical research tradition suggesting that little has changed since independence.

Indian Medical Service officials and eminent researchers Sir Leonard Rogers, Lt Col. Megaw and Sir S S Sokhey in the 1920s and 1930s lamented the utter neglect of medical research in India and criticised the government for its lack of concern. Rogers exhorted Indian industrialists



and philanthropists to come forward to support the cause of medical research and stated that India needed an “Indian Rockefeller” to create a medical research institute.

Private support and initiatives were not lacking. Ramasubban points out, Indian elites were “eager to lay the foundations for the growth of medical science in which Indians could participate and benefit”.

Right:

Sir Leonard Rogers

The Indian Research Fund Association and the Calcutta School of Tropical Medicine received generous support from Indian princes and businessmen. The most notable philanthropic efforts to advance the cause of scientific medicine in India were made by Jamsetji Tata and his son Sir Dorab Tata with their proposals for a School of Tropical Medicine (1918) and a cancer research centre (Tata Memorial Hospital – 1932). International philanthropy, namely the Rockefeller Foundation, was not lagging behind. From the 1930s the Rockefeller Foundation supported the setting up of various medical institutes in the country such as the All India Institute of Public Health in Calcutta (1932), the Virus Research Centre at Pune (1952) and the All India Institute of Medical Sciences in New Delhi (1954). The focus of this study is on the two Tata schemes and the Rockefeller Foundation's virus centre.

RESEARCH FOCUS

What was the State response to these initiatives? What motivated the Tatas and the Rockefeller Foundation to undertake the institutionalising of medical research? What were their concerns? Were these concerns merely philanthropic or based on a world view reflecting larger social concerns? How did the Tatas' thinking and approach compare and contrast with that of the Rockefeller Foundation? This study aims to examine State policy both during the colonial and post-colonial periods towards private philanthropic initiatives to institutionalise medical research. It attempts to examine the interaction focusing on areas of conflict and on compromise between the State and the private philanthropy in the public sphere. Both the Tatas and the Rockefeller

Foundation believed that science was central to human wellbeing and were eager to invest in institutes that would provide training to Indians and inculcate the spirit of scientific medicine in them. However, the political leadership and the bureaucracy appeared unwilling to concede space as conflict centred on location, recruitment policy, composition of governing bodies, and funding. The study proposes to examine, at the general level, State policy with respect to the development of medical research from 1898 to 1962 and, at the specific level, the efforts of Tata and Rockefeller philanthropy to institutionalise medical research. The study is restricted to medical institutes in the Bombay province. The study further examines the role of the various actors and their perceptions and interests as areas of conflict and cooperation.

RELEVANCE

Much of the discourse on the history of medicine in India covers preventive policy, disease control, Indian response and the missionary role. David Arnold and Helen Power have studied certain aspects of medical research policy and the role of philanthropy in organising and institutionalising medical science in India. The present study of the philanthropic role of Tata and Rockefeller in the institutionalising of medical research is significant for examining continuity and discontinuity in State policy from the colonial to post-independent period. The study focuses on a neglected but vital aspect in the discourse on development of medical science in India, namely the interaction between State policy and philanthropy with specific reference to medical research.

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Buddhist medicine in 12th-century Angkor

RETHY K CHHEM

Tantric Buddhism has had a significant influence on the theories and practices of medicine in Angkor at the end of the 12th century CE.

Three notable historical situations are fundamental to the discussion of this paper. First, the foundation stela of the temple of Lolei shows that Ayurvedic medicine was known and practised in Angkor from at least the tenth century CE. Second, Jayavarman VII was crowned King in 1181 CE, after his victory of the Cham who had occupied Angkor for four years. In his efforts to rebuild his shattered kingdom, he ordered the construction of

temples, hospitals, resthouses and a dense network of roads to link them together. Third, by 1200 CE, Muslim raids destroyed major Buddhist centres in northern India triggering an unprecedented exodus of learned monks from famous Tantric Buddhist universities like Vikramisila, who took refuge in Tibet, Nepal, China, Pegu, Pagan, Champa and Angkor.

The arrival of those monks in Khmer kingdom, along with the adoption of Mahayana Buddhism by King Jayavarman VII, contributed to the prodigious development of monastic universities, hospitals and hostels for pilgrims.

Medicine is one of the five major subjects of the Buddhist curriculum that also includes philology, logic, fine arts and metaphysics. Among the major innovations developed by Tantric Buddhism are the use of pulse examination as a diagnostic tool and alchemy as a way to treat disease.

MEDICAL ALCHEMY

Churning of the milk ocean, by both demons and gods leading to the formation of the nectar (*Tuk amret*) of longevity is a well-known legend in ancient Cambodia. This translated into a wonderful architectural design at four of the five gates of the city of Angkor – made of two rows of demons and gods, holding a *Naga* (mythical snake), to churn the ocean.

Epigraphical sources strongly support the practice of medical alchemy in Angkor. The *Ta Prohm* stela enumerates several metals and alchemical apparatus as royal donations from King Jayavarman VII to temples, including mercury, sulphur and a golden cauldron. Zhu Da Guan, a Chinese visitor who stayed in Angkor in 1296, mentioned in his diary that mercury and sulphur were imported from China.

In addition to these written sources, chemical analysis of Angkorian bronze had shown that the Khmer had a good command of metal technology. The transmutation of metal, especially mercury into gold is the process towards the making of the elixir of longevity that prevents the decay of human body and therefore allowing human to become immortal. Although the use of mercury is known in Vedic medical treatises like *Susruta Samhita*, it is only with the development of tantric cults that alchemy has become a major therapeutic method. Also tantric alchemy was an integral part of the Buddhist curriculum in monastic universities of northern ancient India such as Nalanda and Vikramasila. A Khmer Shivaite sect, the Pasupatas were active and influential at Angkor royal court. In ancient India, they were the forerunners of the Siddhas, also called *Yogis*, well-known experts in alchemy. According to the inscriptions, *Yogis* were present in Angkorian Buddhist universities.

All the above evidence strongly supports that alchemical remedies were used in Angkorian medicine. We also know that from the fifth century onward Indian *rasa-cikitsa* (mercurial medicine) was exported, along with Buddhism and Ayurvedic medicine, to Tibet, China, South-east Asia and Sri Lanka. Therefore, a long tradition of alchemical practices has been already established in Angkor, but in the late 12th century, refugee-monks from Vikramasila may have been instrumental to further development of this field in Angkorian medical institutions, because many metals were used in Angkor monastic universities and hospitals.

PULSE DIAGNOSIS

Pulse examination was one of the major diagnostic and prognostic techniques used in Buddhist medicine. The technique has been described in detail in the main Tibetan medical treatise, the *Rgyud Bzi*, translated from the Sanskrit text developed by the Buddhist monks of Vikramasila. Although there is no known similar text in Cambodia, many other ancient Buddhist manuscripts from India have been translated to Tibetan, Cambodian or Chinese. This ancient clinical method has been passed down to modern practitioners of traditional Khmer medicine. It is therefore reasonable to suggest that Khmer pulse diagnosis treatises derive from old Indian manuscripts and have been introduced by Buddhist monks from India.



On the other hand, Bhaisajyaguru, one of the main figures of the Mahayana Buddhist pantheon had been the source of inspiration for the writing of the Tibetan 'Four Tantra'. He is also the major divinity sitting in the chapel of the 102 Angkorian hospitals, which number symbolises twice as much as the 51 mandala of the Bhaisajyaguru, because Jayavarman VII 'doubled' all his foundations in order to worship his parents. Apart from the inscriptions, there is iconographical evidence to suggest the practice of pulse diagnosis in Angkorian hospitals. A bas-relief on the pediment of the Chapel of the Angkor Thom's East Hospital displays a scene of a doctor taking a pulse at the wrist of a patient. Coedes interpreted this bas-relief as a representation of a healer massaging the leper King's forearm, in the context of ulnar nerve paralysis (Coedes, 1940, 345). There are two main reasons for revisiting this interpretation.

The first is the use of biomedical concepts to explain the pathogenesis of leprosy neuropathy not yet known to both Angkorean and Western doctors in the late 12th century. To the contrary, in ancient Cambodia, leprosy is rather attributed to humoral disturbance, and the treatment is made of herbal medicine mixed with cow's urine, not massage (*Susruta Samhita*, 2000, vol II, 375). Second, the patient represented on this bas-relief is not a king as he lacks all the royal attributes such as parasols, banners, peacock feather, etc. This 'overinterpretation' is a common pitfall when one wishes to establish a diagnosis of disease based on an ancient representation of the human body. On the other hand, a definite argument supports the theory that this bas-relief actually displays a 'pulse diagnosis scene' and therefore supports the role of the Bhaisajyaguru as the central divinity in the shrine of Angkor hospitals, and who is described as the divine founder of pulse diagnosis in Buddhist medical manuscript. What could be more powerful evidence than a scene of pulse diagnosis in a hospital's chapel in honour to a divinity who had been the supreme teacher of this technique?

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Top right:
Bhaisajyaguru
(the medicine buddha),
the central divinity
in the shrine of Angkor
hospitals.

Medicine at the Border

ALISON BASHFORD

Stranded one day at LA airport – all flights to Toronto were cancelled because of SARS – a conference began to materialise in my notebook. It turned into ‘Medicine at the Border: the history, culture and politics of global health’, held at the University of Sydney 1–3 July 2004.

If, to use contagion/causation metaphors in a slightly unusual way, the ‘proximate cause’ of the conference was SARS, the ‘predisposing cause’ was the wave of recent scholarship on public health, nationalism and borders. And the ‘remote cause’ was the intriguing talk at various papers, dinners and coffee breaks at Mick Worboys and Flurin Condrau’s tuberculosis conference in Sheffield some years ago.

The Australian government was kind enough to grant visas for a number of historians and sociologists from the UK – Richard Coker, Sally Sheard, Ian Convery, John Welshman, Sanjoy Bhattacharya and others. But for speakers from other nations, this was not the case. The opening irony of the conference, which for me gave great import to our talks and exchange, was that several speakers from India, Senegal, Cambodia, Taiwan and Indonesia were subject to Australia’s notoriously rigid health criteria for entry visas (from certain nations categorised as high TB risk). In several cases, entry visas were either not granted, or the expense and difficulty of undertaking the various chest X-rays and tests were prohibitive or simply not worth the hassle. A carefully planned ‘global’ program was flattening out into a conference dominated by US, UK, Australian and New Zealand speakers. And fabulous they were but the exercise was a clear object-lesson in thinking about how the net effect of such ostensibly neutral risk-based epidemiology and security structures is remarkably close to the old white Australia. And I offer that not flippantly or even provocatively, but strictly historically: the legal basis of the white Australia policy similarly never explicitly discriminated, or even mentioned ‘race’ either.

Thus when Richard Coker, London School of Hygiene and Tropical Medicine, opened the conference with his assessment of contemporary migration screening and infectious disease control, the issues were immediately pressing. Current British official interest in ‘the Australian model’ of rigid pre-entry screening, made it even more so. The conference was well placed to discuss the histories which had produced current medico-legal border control, to compare histories and processes of regulation, and to think in a really informed way about

moments and places where this was not the case. For me, one strand which emerged was the more acute sense of national ‘hospitality’ and global responsibility in the immediate post-World War II period, than the global situation now. And Heather Worth, speaking of HIV-positive refugees, offered a fascinating political theorisation of ‘hospitality’ in precisely this context.

One of the most interesting lines of inquiry to emerge, I thought, was the question of the place aspect of the process of screening. Hans Pols offered a paper on Ellis Island mental hygiene screening, John Welshman spoke of TB screening more recently at Heathrow. These ‘onshore models’ were/are vastly different to the tradition of ‘offshore’ pre-entry screening (in London) for intending emigrants, which Australian governments had long insisted upon. Indeed in what ways are various histories of onshore/offshore health screening related to current (vastly different) national practices of screening people for refugee status? Several papers took up links between refugee issues and health issues, and the conference drew considerable attendance from clinicians and public health policy makers in that field.

A carefully planned ‘global’ program was flattening out into a conference dominated by US, UK, Australian and New Zealand speakers.

I think that public health historians and epidemiologists are temperamentally twinned. We both want to know and explain (if differently) what happens over time and over place. This was certainly one of the successful emphases at the Sheffield tuberculosis conference, and I hoped to replicate such fruitful interdisciplinary exchange in Sydney. While that is for others to determine, my sense is that interest from the state health department, the Commonwealth quarantine service, and public health academics, both local and international, came to shape much of the conference discussion.

The other strand of inquiry which emerged for me, was rather more about the ‘global health’, than the ‘border’ aspect of the conference title, although the two are obviously related. Elizabeth Fee detailed a broad shift from the use of ‘international health’ to ‘global health’, and offered analysis of why this might be the case, and what its effects may be. Sociologist Lorna Weir took up questions of contemporary global communication of information on communicable disease, and the new media used for surveillance, information retrieval and dispersal. Such communication often works outside national systems altogether. A fascinating 20th-century history emerged from intense use of public health rationales in post World War I national border arrangements (Patrick Zylberman) to colonialism,

internationalism and disease eradication (Sanjoy Bhattacharya) to globalisation and disease (Lorna Weir). And that was before we got onto SARS. Carolyn Strange's semiotic analysis of Toronto's touristic repackaging of its image during and post-SARS, examined a peculiar, desperate and (it has to be said) daggy attempt to make itself insistently not 'third world'. The complicated and important links between culture, commerce and communicable disease in the 21st century were skilfully laid out before us.

Finally, for me the conference opened up more fascinating questions about the relationship between colonial networks and international networks. Papers on colonial public health in India (Mridula Ramanna, Jo Robertson, Jane Buckingham) and on 19th-century

ocean-oriented networks of health, quarantine and ports (in particular Sally Sheard's paper) were very interesting indeed to place against scholarship on the emerging world health logic of the 20th century. The question of how tropical medicine functioned as a hinging discourse between the 19th and the 20th century, between 'imperial' and 'world' is, I think, an open one.

A conference report from the conference organiser is a peculiar thing. Nonetheless, at least it gives me another chance to heartily thank the participants (and indeed those who couldn't make it) for their contributions.

Dr Alison Bashford, University of Sydney, Australia.

The History of Dreams and Altered States, Part II

MELANIE CLEWS

In the second of two symposia on 'The History of Dreams and Altered States', Rhodri Hayward and Michael Neve put together an excellent group of speakers for this cross-disciplinary event.

Forming a rich investigation on the theme of dreams and altered states, each paper differed in approach and perspective. In addition to an examination of their content, their differences also identified broader questions about historiography and methodology and the complexity involved in an historical analysis of what is primarily a private, introspective experience. The rationale behind this second symposium was, according to Hayward, "a desire to create an alternative history to the Freudian studies that had been done many times before. The idea was to engage with scientific studies that would include an examination of the impact of modern technology on dreams and dreaming".

Sonu Shamdasani opened the event with an impressive paper that traced a 'genealogy' of contemporary dream culture, touching upon analogies of dreams to madness, and the 19th-century annexation of discourses on dreams by psychology. Sonu ranged his longitudinal history of dreams within modern European thought across the philosophical ideas of Descartes, Kant and Locke on the nature of identity and the meaning of sleep and function of dreaming.

Right:

The child's dream of pantomime
Wood engraving by
Arthur Crowquill

While an alternative historical discourse to that of the psychoanalytic framework formed a basis for this



conference, a total omission of Freudian psychoanalysis would have resulted in an uneven discourse.

It was thanks to John Forrester's interesting and enjoyable paper "I'll let you be in my dreams if I can be in yours" Bob Dylan: Freud's Place in Twentieth Century Dreams', that this didn't occur! Citing a great selection of examples, including the Bob Dylan song in the paper's title, Forrester argued that "Dylan's jostling with the psychiatrist-at-the-end-of-the-world is emblematic of many cultural responses to the invasion of the interior life by Freud". Forrester also explored "the means by which Freud's theory of dreams insinuated itself into the dreamworld of the twentieth century". Picking up on the theme of the impact of modern technology on our interior life, John Forrester suggested that dream analysis and film production could be regarded as parallel cultural forms because "cinema, like psychoanalysis, is constitutionally disposed towards ignoring the distinction between reality and fantasy, between reality

and dream". This theme of dreams in relation to changes in both technology and analytic technique was expanded in Antonio Melechi's paper 'Lucid Dreams'. Melechi traced the development of practical techniques of 'lucid dreaming' beginning with the work of Stephen La Berge.

Whereas Antonio Melechi offered a narrative reconstruction of the evolution of new dream techniques, Joanna Bourke drew out the methodological implications of such studies, arguing that they must include an exploration of the lived, bodily experience of the dreamer. Her paper, 'Nightmares: A History', suggests an historical approach to people in the past "that acknowledges the history of bodily and emotional reactions to the world". Through examination of archival accounts of nightmares, Bourke asks "what nightmares are doing" historically?

In Douwe Draaisma's paper, 'Panoramic memory: a brief history of the metaphor "I saw my life flash before me"', different metaphors are examined to locate the historical constancy, should there be one, of the 'near-death experience'. The fact that research indicates that the near-death experience is consistently reported as something outside ordinary experience has meant that, according to Draaisma, recollection usually resorts to metaphor, and closer investigation reveals that the metaphors used are historically specific. In the age of cinema, such experiences usually take the form of a projected film. Draaisma's analysis echoed themes from the papers of Forrester and Bourke – Joanna suggested that changes in the narration of nightmares altered the subjective experience of dreaming; Jung's nightmares were embedded with Jungian theory filled with Jungian symbols, and Freud's, Freudian imagery.

The final two papers from Kenton Kroker and John Geiger both demonstrated the central role of technology in mediating our dream experiences. Kroker focused on the development of the 'sleep laboratory' and discovery of REM, showing how this prototypically subjective experience of dreaming was turned into an object of scientific investigation. His political account traced the links between private experience and public enterprise, an approach which was paralleled in John Geiger's lecture on Flicker and the History of the Dream Machine. Geiger explored the "intersection of art and science within the transcendental worlds evoked by stroboscopic light". He traced the evolution of the dream machine from the first discovery of 'flicker potentials' by the Bristol neurophysiologist, Grey Walter, through its development into a hallucination generator by beatniks such as Brion Gysin and Ian Somerville, into its eventual development into the 'Dream Machine', which the electronics company Pye had hoped to install in every suburban living room.

This was a convincing and engaging symposium, with excellent papers. As already mentioned the historical methodology embedded in some of the papers raised further questions. Although the papers were addressing, in different ways, a history of what is essentially a subjective experience, this only revealed the need for more inter-paper discussion to challenge some of the assumptions and problems of historiography. I would have liked to have seen extra session at the end of the day to bring the papers together on the theme of methodology. This was, otherwise, an excellent, enjoyable and different approach to a history of dreams and altered states.

Melanie Clews, Queen Mary and Westfield College at the University of London, UK.

Municipal Medicine

JOHN STEWART

A two-day workshop on municipal medicine was held at St Edmund's Hall, Oxford, 1–2 July 2004.

It was convened by Martin Powell (University of Bath), John Stewart, Alys Levene and Becky Taylor (Oxford Brookes University).

The workshop was part of a wider project on municipal medicine in interwar England and Wales funded by the Wellcome Trust. The convenors aimed to bring together some key voices working in the field of municipal medicine, as well as disseminating work from their current project.

Contributors to the workshop were Anne Crowther, Martin Gorsky, Greta Jones, Pam Michael, John Mohan,

Chris Nottingham, Martin Powell, John Stewart and Becky Taylor. Bernard Harris, Anne Hardy and Virginia Berridge chaired the sessions. The papers covered a wide range of quantitative and qualitative aspects of the high period of municipal medicine. These included explorations of specific municipal health systems – with examples from Gloucestershire, Eastbourne, Glasgow, Wales and The Netherlands – and of particular services, and the structural and local factors affecting local authority health services. Other papers took a more quantitative approach in order to explain the pattern of hospital appropriation following the 1929 Local Government Act, and the distribution of voluntary and state service provision.

It was a very productive two days, and in the round table discussion chaired by Kier Waddington there was the opportunity to explore a number of inter-related themes, which had emerged from the papers.

One of the key threads running through many of the papers was how the diversity of municipal solutions to provision of personal health services was reflected in the diversity of localities. Therefore a variety of local influences must always be factored into any construction of interwar service development. In this context participants discussed the respective role of economic determinism during the economic crises of the interwar period; politics and the rise of Labour; the role of the Ministry of Health; and the existence of progressive institutions and individuals in shaping service provision. Other factors which came to the fore were the impact of civic pride and civic competition, and the influence of class and gender in steering the amount of investment and the direction of local health service development. Consequently the idea of boundaries emerged as a key to understanding the period – not simply geographical boundaries, but also

institutional ones and between the voluntary and municipal sectors. Boundaries could isolate particular services within their particular municipal authority or divide one authority from another; equally they could be blurred through strong inter-departmental cooperation, joint schemes between local authorities, or by close coordination of the municipal and voluntary sectors.

The discussion closed by exploring the relationship between failures and strengths of municipal medicine and the emergence of the NHS.

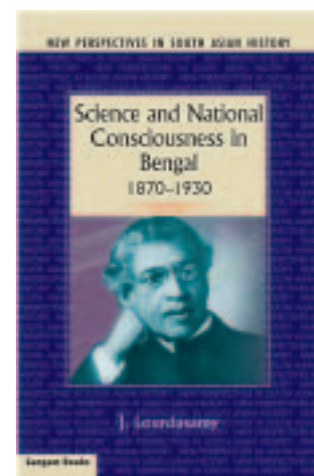
The convenors would like to thank everyone who participated, and the Wellcome Trust for their financial support. To find out more about the project on interwar municipal medicine, please contact John Stewart or Martin Powell at (E jwstewart@brookes.ac.uk) or (E hssdmp@bath.ac.uk).

Science and National Consciousness in Bengal, 1870 – 1930

J LOURDUSAMY

This book gives a flavour of the Indian response to modern science by analysing the lives and careers of four scientifically influential personalities in Bengal. It throws light on some of the complex and paradoxical issues attending India's engagement with modern science in the context of colonialism. While explicating the nuances of the response, this work also contests some broad generalisations which have a bearing on the subject.

Lourdusamy uses this study to emphasise the importance of a prosopographical approach. His analysis of the careers of two scientists, J C Bose and P C Ray, and two institution builders, Mahendralal Sircar and Asutosh Mookerjee, brings to light the issues related to science at a time of colonialism and nationalism. Scientists often had to depend on British institutions for legitimisation and funding, while also supporting the nationalist cause for greater autonomy. One of the central claims of this book is that the protagonists aimed to contribute to a modern world science, one based on a strong sense of universalism. They did not aim to construct any 'alternative' sciences, though they did express and apply their work by drawing on their cultural heritage. This makes *Science and National Consciousness* a work of particular relevance today, when a homogenous, instrumentalist and totally Western conception of science is being globally accepted.



J Lourdusamy is Assistant Professor in the Department of Humanities and Social Sciences at the Indian Institute of Technology Madras, which he joined after his doctoral studies at Oxford. His broad areas of interest include history of science and the interaction of science and religion.

For purchase information, contact Orient Longman (E editor@pol.net.in)

The Bombay University Library

MRIDULA RAMANNA

The University of Bombay was established in 1857. In 1864, Premchand Roychand, a rich merchant, offered a donation of Rupees 200 000 “towards the erection of university library which may be an ornament to the city, and by becoming a storehouse of the learned works not only of the past but of many generations to come, may be the means of promoting the high ends of the University.”

This was followed by another gift of Rupees 200 000 for a clock tower to be erected in memory of Roychand’s mother, Rajabai. Designed by Sir Gilbert Scott, the foundation stone of the structure was laid in 1869, and completed in 1878. The clock tower rises to a height of 280 feet and with the library building is a landmark in Mumbai (Bombay). Among the building’s many unique features are the stained glass windows and the sculptures, above the first gallery in the niches, representing the various communities of Mumbai, including the Parsi, Memon, Maratha, Gujarati and Kathiawari. Maclean’s *Guide to Bombay* (1880) recorded with pride: “A noticeable feature in the work and one which speaks volumes for the way in which it has been managed is that during the whole time of the construction not a single accident has occurred.”

The library opened, in 1880, with a *conversazione*, when eminent medical men conducted experiments. At the time, it had an odd assortment of historical and biographical books, presented by the government, when the library of the East India Company was removed to the India Office and some books were divided among Indian universities. In 1876, the university purchased the books owned by Dr John Wilson, founder of Wilson College, and university vice-chancellor between 1868 and 1870. These were on ‘oriental’ interests, travel and theology. Initially, Rupees 400 was provided annually for the purchase of books and soon even this was discontinued. In 1888, there were only two readers, the additions that had been made to the library being official publications of the government and some school and college books, presented by publishers. As a result by the end of the 19th century, the library had 4504 books and 214 manuscripts. Gradually the library came into its own, with an annual grant, the amount varying, according to circumstances. The windfall came in 1930, when a non-recurring grant of Rupees 60 000 was given to strengthen the library for post-graduate work. Thereafter, funds kept flowing, and by 1956, the library had 125 000 books, and 1190 manuscripts in Arabic, Urdu and Persian and 7418 in Sanskrit and other allied languages. This source material has been growing in subsequent years.

Descriptive catalogues of manuscripts list the treatises on medicine. Among the interesting titles are *Ajimananjari*, a treatise on indigestion and its remedies; *Anjananidana*,



which deals with eye diseases; *Yogatarangini*, a manual of dietetics and therapeutics; *Jvaraparajaya*, which discusses fevers; *Asta Pariksha*, which gives the eightfold method of diagnosing diseases; and works on materia medica and on the preparation of syrups, powders and oxides. The Arabic manuscripts include a dictionary of medical terms, and *Al Hikmatu’ T-Tibb*, describing the symptoms and treatment of diseases.

Of particular value are the library’s rich collection on Mumbai. It has all the census reports, annual reports of the sanitary commissioner, public health, civil hospitals and dispensaries, administration of the Bombay Presidency, the municipal commissioner, city of Bombay, the Grant Medical College, proceedings and debates of the legislative councils, Bombay University calendars, with the lists of graduates, and extracts from Indian newspapers published weekly (invaluable for understanding Indian responses to colonial policy). The library also has reports from other presidencies, and proceedings of medical and sanitary conferences, little-known works, of the 19th and early 20th centuries, by Indian doctors, besides those by British health officials, Andrew Leith, Charles Morehead, T G Hewlett and J A Turner. There are specific records pertaining to plague, cholera, smallpox, leprosy and malaria. Of particular interest are the issues of the delightful *Pickings* from the *Hindi Punch*, which carried cartoons on issues of health.

Together with the even richer Maharashtra State Archives and the library of the Asiatic Society of Mumbai, the city is a treasure trove for medical history researchers.

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Top right:

The clock tower of the Bombay University Library
Image courtesy of Sanjoy Bhattacharya

India and the USA: A researcher's reflections.

ALEX MCKAY

There are many similarities between India and the USA. Both are vast countries with a wealth of cultures and landscapes, extremes of climate and beliefs, and fractured, turbulent histories that still challenge their futures.

They are both democracies where the everyday practice of religion exists amidst a secular framework and personal proclamations of faith are unblushingly made by politicians and passers-by alike. Both provide the visitor with an intense encounter, fully engaging the mind and body. But for the academic researcher it is the differences between the two lands that are most immediately apparent.

You don't get body-searched going into the Library of Tibetan Works and Archives in the Himalayan foothills above Dharamsala, north India. Nor do you have to pass through a metal detector and wait while uniformed guards rummage through your bag and check your shoes for explosives, as you now do to enter the Library of Congress in Washington DC. You don't even need to apply for a reader's card. But the collections of the Library of Congress reflect all the wealth and splendour of a 20th-century superpower, while for all its efforts the Tibetan library reflects the struggle for resources in an exile community.

I recently carried out research in archives and universities in India and the USA as part of a Wellcome-funded project to trace the history of the introduction of biomedicine into the Indo-Tibetan Himalayas. Thus I came to reflect on the different research strategies required in the two countries.

The most obvious difference perhaps, is that of time. Research can be done at pace in the USA. Librarians, themselves pressed for time, dispense crucial information quickly and efficiently with the minimum of notice. Broadband computer connections and comprehensive online catalogues enable relevant material to be quickly ordered. Study areas are spacious and equipped with computer connections. Work proceeds at pace. In the Himalayas, however, the pace is somewhat different. Tibetan etiquette, for example, demands a preliminary call on the relevant official, an outlining of the proposed work and a discussion over how best it might be done. Commencing the actual work is politely left until a subsequent date. The researcher following such conventions will lose time, but in return gains social acceptance, and may thus be informed of sources that might not be revealed to less sensitive enquirers.

Information is power, and whereas in the USA a keeper of archives is a facilitator, in India the researcher often enters into a power relationship. In return for access to

sources there are expectations of mutual benefit.

A library may need assistance with an application for sponsorship from a Western benefactor, or the librarian may need assistance in locating a suitable European university for his son to apply to. Contributing to the relationship takes time, and perhaps even money.

Locating sources can be similarly time-consuming. There are few archives in the USA that cannot be quickly located via an internet search. Academic resources in India, however, are less systemised. Records of a period may still be in the possession of a local Maharajah. The records of the state are for them family records, accounts of a period in which their forefathers were the government. Thus the creation of an understanding of the local historical context of medical development requires an appointment with the Maharajah, whose perspective provides new insights not given in the records of the British colonial state. But one does not simply turn up at a Maharajah's door at 9 a.m. ready to start work. They invariably have many business interests and social commitments, and the researcher must join the queue.

In India the researcher often enters into a power relationship.

The need to see specific individuals can be particularly labourious. Both the nature of interviewing and the hierarchal nature of bureaucracy is such that certain officials are recommended by all as 'the person to see'. But that officer is invariably 'engaged at court' or 'out of station' at any time in the immediate future. Days pass with frequent cups of tea proffered by friendly lesser officials, along with assurances that the subject will eventually return.



Right:

Shops in
Chamba Town

Image courtesy of author

One church official I sought, reputedly the key to all knowledge of the early medical missionaries in that district, proved particularly tardy. I filled in one day searching for an alternative voice; a relative of the absent ecclesiastic who was said to have fallen out with him many years before. When I eventually found his house in the back streets of the bazaar, I was solicitously informed by his neighbours that he had actually died some months previously. And when the missing church official finally returned a week late, he proved to actually know very little about the missionaries. But he did know a considerable amount about the mission's house and the land they had had, because he now occupied it, and hoped to gain my support in the long-running lawsuit over its disposal.

Travel in India takes up considerable time. India's infrastructure has greatly improved in recent years, but it can still take hours to buy a train ticket, and reservations for a particular day can be impossible to find. Similarly Himalayan roads are subject to landslides, and the wear and tear on vehicles on mountain roads means breakdowns are frequent. What is scheduled as a morning's drive is liable to take all day. Planning ahead can thus be difficult, if not impossible.

Nor can one put in long hours at the archives. The main library of the University of Chicago is open at least 14 hours a day, and sometimes overnight. In India, however, an eight-hour day is usually the maximum even in theory, while the inevitable power cuts may reduce that time still further, and also prevent 'catching up' work in the evenings at one's hotel.

There is also a different culture of historical preservation. In the USA records are recognised as a resource; the papers of even a minor historical figure may fetch a considerable sum at auction. But medical history is hardly a priority in India, where scant resources can barely cope with the present. Many Indian hospitals destroy all records after a few years, and even those files that are stored are often kept in unsuitable locations. A monsoon season or two, and the attentions of insects and rodents, means they are soon unusable.

Even when local medical records are retained in government archives they are not necessarily safe. Most of the colonial-era records kept in Simla, the British imperial summer capital, were destroyed in a fire in the 1950s, and the Simla archives are thus of little value to the imperial historian.



What can be found is often revealed by chance. While I waited a week for my churchman, I often chatted to an elderly man living near my hotel. He talked to a friend who worked at the local hospital, where I had been told that no records were kept of the colonial era. But purely as a curiosity, the friend had kept a 1920s hospital pay-book he had found behind a cupboard, and that pay-book turned out to be a useful primary source for me.

Such personal discoveries, and the joy of working in the beauty of the Himalayas, are more than adequate compensation for the difficulties of research there.

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Top right:

Chamba Town

Image courtesy of author

Blood and Guts

ALAN SHIEL

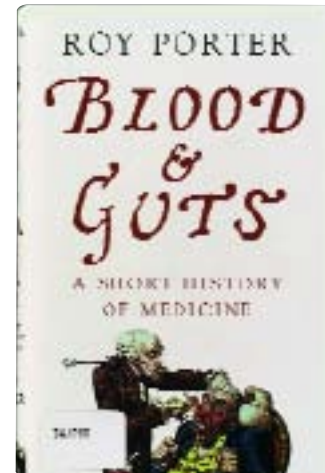
When Roy Porter published his book called *Madness: A brief history*, I told him that it had been reviewed in a major broadsheet. He enquired about the review and I said that the reviewer had said it was quite good but rather brief. Somewhat uncharacteristically Roy replied, “Bloody fool, hasn’t he read the title?”

Well, I have read the title of Roy Porter’s latest book *Blood and Guts: A short history of medicine*. Apart from the inference that it might be somewhat demotic in style, it is a totally accurate description of the contents. It is an extraordinary *tour de force* taking the reader through the history of medicine from mankind’s arrival on earth to the current state of the National Health Service in the UK. It is certainly not the last word on the history of medicine but I think that for many readers it may be the first word. It is an ideal introduction: informative, fascinating without any suggestion of ‘dumbing down’.

The book is based on a series of lectures which he gave and that allows him to provide complete stand-alone chapters on such topics as ‘Disease’, ‘Doctors’, ‘The Body’, ‘The Hospital’, and so on. It is not to denigrate the content of the main part of the book if I say that possibly the most important section comes at the end, in his list of further reading where, informally but thoroughly, he sets out in 17 pages a list of further books. In the rare use of an exclamation mark he notes that Jackie Duffin’s *A History of Medicine: A scandalously short history* is “actually 430 pages long!” By way of comparison *Blood and Guts* runs to just 199 pages; just how scandalous is that? For those of whom this is their first book in the history of medicine this is an invaluable resource.

Roy Porter’s lecturing style is evident in the way each chapter is written. Full of information, anecdote, humour and challenging theory, it is not hard to imagine Roy standing before a class and telling his spellbound audience about ‘Lily the Pink’ (whom I had previously supposed to be the invention on the 1960s pop group The Scaffold) and the early uses of amyl nitrate! The book sadly but inevitably fails to include the hilarious and possibly scandalous asides and digressions that would have followed from a discussion of such matters.

Roy Porter’s lifelong scepticism about the efficacy of much medical treatment is never better highlighted than by his account of the function of prescribing pills at the close of a brief consultation: “It’s a nice way of getting rid of a patient, you scribble something out and rip the thing off the pad. Doctors can now cure as never before: the public may doubt whether they care.”



Although continuing to be wary of ‘quacks’ (e.g. the “electrified Celestial Bed” provided by James Graham at his Temple of Health, which promised long life and sexual regeneration), Roy is not unsympathetic to alternative approaches to healing *per se*, nor to those who turn to them. He describes how alternative healing philosophies often mirrored religious dissenting sects and sociopolitical radicals: “Artisans distrustful of princes and prelates were no more disposed to swallow the medicines of privileged Colleges.”

Roy has seldom used his books to regale his readers with his political opinions (a brief and effective exception appears in *London: A social history*) but he leaves little doubt in the mind of his readers that he considers the current attitudes in and towards the National Health Service unhelpful. He does not coin the slogan ‘over-management kills’ but there is little doubt that he would subscribe to such a view. It would not be a wild flight of fancy to imagine he felt the same about other leading British institutions such as the BBC and the university sector of higher education. In the face of current trends at most seems almost quaint his plea for the return of the ‘personal touch’ approach in medical care.

Is an ideal introduction: informative, fascinating without any suggestion of ‘dumbing down’.

In *The Human Effect in Medicine* by Michael Dickson and Keiran Sweeney (also recently published) there is a complaint that “modern medicine has lost its heart and soul and become mechanistic. The new GP contract talks about measuring cholesterol and blood pressure but what patients want is a doctor who will listen, talk with them and understand them.” I doubt that Roy Porter would have dissented from such a statement.

Roy Porter was never gloomy let alone apocalyptic; it was not in his nature to be. We should therefore take serious notice of his view that drug abuse and dependency – by no means only in the guise of illegal narcotics – means there is an urgent problem for medicine and society alike. Roy Porter concludes his book with the warning that medicine may be on the brink of one of the greatest transformations in its long and chequered history but the public climate is not one of optimism but of new millennium anxiety.

If anyone continues to doubt that ‘history matters’ or that the lessons of the future are to be found in a

study of the past then they would do well to read this book. I am sure it will be widely read by newcomers to the subject and by accomplished historians of medicine. In writing this review I became conscious of the danger of being part of a ‘Death of Roy Porter Industry’. In life Roy hated sycophants and flatterers; in death he may have to put up with us!

Blood and Guts: A short history of medicine is published by Penguin Allen Lane at £12.99.

Alan Shiell is at the Wellcome Trust Centre for the History of Medicine at UCL

Heroin Addiction Care and Control: The British system

ANN DALLY

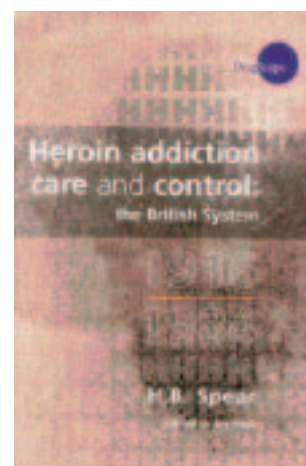
Anyone who knew ‘Bing’ Spear well in his professional capacity will know that, behind his bureaucratic even-handedness as a civil servant, lay passion and strong beliefs. He was Chief Inspector of Drugs at the Home Office, with more than 35 years’ experience of the drug scene in Britain. He had seen it develop and he knew it intimately.

As a civil servant, he could not express his views publicly but he often said that, when retired, he would reveal all. This he has now done. Unfortunately he died before he finished the story, which he tells up to two years before his retirement. Those two years were full of incidents but nevertheless he has covered most of it and the manuscript has been ably edited by a former colleague of his, Joy Mott.

Spear believed, as do many others, that the British (following the American) policies concerning heroin have failed. Prohibition has led to ever-increasing addiction and to a vast amount of crime and suffering. The situation was made much worse because the treatment centres, set up in the 1960s when heroin was becoming a problem, were, according to Spear, “an unmitigated disaster”.

This was “not because the basic idea was wrong but because of the way in which that idea was developed and implemented”.

For this Spear blamed “a small group within the medical establishment”, and “psychiatrists in particular”, led by the late Dr Philip Connell. These doctors, with little experience of treating addiction, imposed their own views on the situation and took steps to ensure that other doctors and GPs, who traditionally treated addicts, were kept out of the scene, and often that all



addicts, whether they had been addicted for three weeks or 30 years, should be treated the same. In life Spear was vociferous in his condemnation of this group of “drug dependency mafia”, and he sets out his arguments here.

The book is authoritative and quite different from what anyone else has written. It is an invaluable addition to the history of heroin in Britain.

Spear H B (2002) *Heroin Addiction: Care and control: the British system*, edited by Joy Mott, London: Drugscope. pp.362, £35.

Ann Dally is at the Wellcome Trust Centre for the History of Medicine at UCL.

Inventing Global Ecology: Tracking the biodiversity ideal in India, 1945–1997

PRATIK CHAKRABARTI

This highly interesting book engages with various areas of modern scholarship: ecology, modernity, cultural imperialism and post-colonialism. The main argument is that the USA role in shaping Indian ecology since independence needs to be seen as one of collaboration, distinct from the British colonial one.

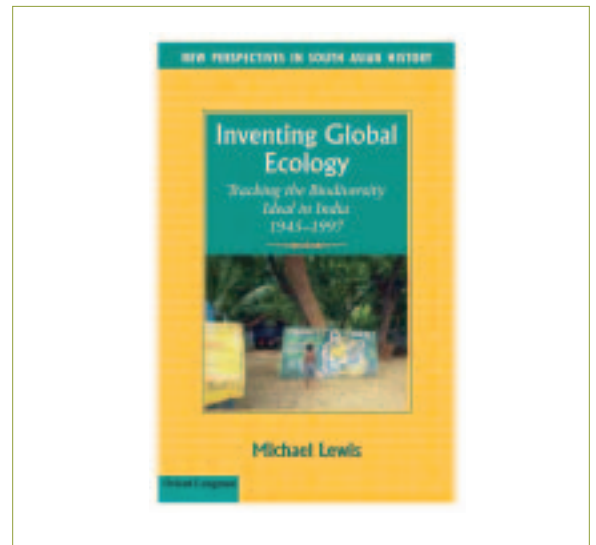
US scientists like S Dillon Ripley did not carry the ‘colonial burden’ in interacting with Indian naturalists like Salim Ali. The book discusses contributions of George Schaller and Juan Spillett who came to India as part of the diasporas of US ecologists throughout the world from the 1940s in search of wilderness and solitude, with the urge to expand a new discipline beyond the ‘frontiers’. They and others formed strong linkages with Indian scientists and institutions leading to the emergence of an ecological science for Indian ecosystems, where Indians like Madhav Gadgil, Raghavendra Gadagkar and Raman Sukumar, actively ‘localised’ US biological concerns.

The book reads like a delightful travelogue describing the author’s intellectual journeys with Worldlife Institute of India (WII) researcher Christy Williams in Rajaji Park. As a historical monograph its study of the contribution of the pioneer Salim Ali, establishment of Bombay Natural History Society and its linkages with Indian nationalism provides a much richer reading of Indian ecological history than that by Gregory A Barton (*Empire Forestry and the Origins of Environmentalism*, Cambridge University Press, 2002).

Despite its detailed study of ecological debates, Lewis provides a rather ahistorical explanation for complex historical processes like the evolution of ecological ideas in the USA, as well as the early 20th-century development in German physics, Italian Renaissance, and Indian nationalist thinking, which according to him were “an unexpected outpouring of brilliance” (pp.338–9). In regards to ecological thinking in the USA, it must be pointed out that key historical works in that field (e.g. Donald Worster, *Nature’s Economy: The roots of ecology*) get unmentioned.

Lewis tends to over-simplify the issue of ‘cultural imperialism’

Coming back to collaboration and the emergence of new knowledge, Lewis distances himself from Arjun Appadurai’s notion of public culture to set out a deeper project, the study of “... the role of power relations in what knowledge is accepted and codified, versus rejected or marginalised” (p.26).



Lewis provides a rather ahistorical explanation for complex historical processes like the evolution of ecological ideas in the USA

But the narrative gets embroiled in a debate with ‘cultural imperialism’, which limits its scope. Lewis tends to over-simplify the issue of ‘cultural imperialism’ which according to him, “assumes that all global exchanges are trumpets – fairly inflexible products of one culture”, (p.335), and in another instance, “The idea of cultural imperialism implies that things have pure origins” (p.337). Few scholars working on imperialism and culture would make such claims. Notably neither of these statements are attributed to any book or scholar. Lewis elsewhere has engaged with Shiv Visvanathan’s critic of Western science, but one of Visvanathan’s articles that Lewis has discussed in fact sets a very different tone:

“India today stands as one of the world’s great clearing houses and compost heaps for ideas... This is best seen in the attitude to its three greatest imports: democracy, the English language, and modern Western science. For Indians these were not alien ideas to be handled with suspicion but celebrations, which they had to internalize and reinvent for themselves. Indeed, the confidence and openness with which India greeted and scrutinized science constitutes one of the most fascinating chapters in the encounter between science and democracy”.

Thus Lewis ends up denouncing what is quite indefensible. His conclusion that: “it is difficult to imagine how Indian ecology would have developed in the absence of

the USA, so intertwined are the two nations' ecological sciences, but at the same time it is clear that Indian ecology developed along its own lines, fulfilling the goals of Indian actors, be they scientists, activists or bureaucrats" (p.340) is hard to distinguish from Appadurai's theme of negotiations in public between the cultural producer and the consumer.

While Lewis has successfully argued that US participation in Indian ecology cannot necessarily be seen as an imperialist project, other issues remain, like the one with which he started, that do synthesis and syncretion exclude the question of power? Lewis effectively critiques Ramchandra Guha's suggestions of US dominance in Indian ecological thinking but intriguingly avoids engaging with the important literature on the subject which has suggested a more nuanced understanding of the production and absorption of ecological expertise, while specifying how power and politics continue to play their roles in the struggle for resources in the diminishing forests.

Christy Williams' comment, "everyone else has a voice, and the elephants have only the biologists" (p.15) reveals the dichotomy that exists between scientists and human rights activists in Indian ecological debates.

US ecological science, while sympathetic towards Indian flora and fauna, has been found inadequate to tackle the unique problem of Indian forests which often have dense human settlements. The issue is as much ecological as sociological. But a quick look at the faculty of WII reveals that it still comprises people from biology, botany or zoology backgrounds, while social activists continue to oppose a science which they claim does not reflect their concerns. Lewis refers to this problem as a gap between the rural and the urban understanding of forest management (p.110) but does not elaborate on it. One breakthrough from this impasse might lie in a deeper interaction between these sociological concerns and ecological science towards a more composite understanding of the forest and its inhabitants, and thus an integration of 'Indian' concerns within the science of ecology, one of the key themes of the book.

Lewis M. *Inventing Global Ecology: Tracking the Biodiversity Ideal in India, 1945–1997*.

New Delhi: Orient Longman; 2003; pp. xi + 369; Rs. 675, ISBN 81 250 2377 1.

Dr Pratik Chakrabarti is the Deputy Director and Unit Research Officer at the Wellcome Unit for the History of Medicine, Oxford, UK.

Framing and Imagining Disease in Cultural History

KAI KHIUN LIEW

Aside from official accounts, newspapers, poetry, novels and autobiographies are all alternative and legitimate sources in framing the discourses on the history of medicine.

From a broad compilation of articles spanning across the Early Modern period to the present, the contributors of *Framing and Imagining Disease* seek to demonstrate the fluctuating interpretations of health and diseases through the articulations of historically acclaimed literary personalities and ordinary subjects outside the medical profession. Such accounts cover areas ranging from psychiatry to epidemiology, from New York to India.

While their efforts are commendable, questions remain on the extent to which this work is capable of steering research directions and paradigms within the increasingly related fields of history, medicine, culture and society.

Framing and Imagining Disease is one of the concrete outcomes of ongoing multidisciplinary dialogues from 'a consortium' of scholars interested in the cultural understanding of illness. To begin with, readers are faced with a lengthy introduction by George Rousseau, the editor, on the basis and background of their approach in deciphering diseases through literature and poetry. In this respect, Rousseau identifies two fundamental approaches in the historiography. They are the dominant 'Rosenbergian' (from



Charles Rosenberg's works) enterprise of viewing the discipline through macro-social arrangements and the emerging 'Rousseauvian' group that gravitates its research towards individual voices. The volume is divided into four main sections, namely, on framing and imagining diseases, madness and psychiatry, the narratives of the patients, as well as the poetics and metaphors of diseases.

In the first part, Caterina Albano dissociates the contemporary understanding of anorexia with the

notions of self-starvation as a continuation of the medieval traditions of religious piety and asceticism in the 17th-century case of Martha Taylor, otherwise known as 'Derbyshire Damosell'. Basing on the poetries and treatises on smallpox in the same period, David Shuttleton discusses the relationship between the notions of inherited sin and disfigurement with that of self-dignity of facially scarred survivors of the disease. Moving to 19th-century New York, Jane Weiss highlights the complexities of the responses to the cholera outbreak in 1832 by tracing the shifting of journalistic paradigms from casual dismissal to feverish distress. Across the world in colonial India, Pamela K Gilbret equates the attempts by British colonial officials in the subcontinent to map out its medical cartography as both epidemiological tools, and, as arguments for pushing for social development and modernity to the 'backward natives'.

Overall, the organisation and quality of the contributions in the volume are pleasing.

Moving forward to 20th-century Germany, Malte Herwig highlights, through Thomas Mann's *The Tragic Mountain*, the varied responses from the medical establishment to alternative interpretations from otherwise lay sources. In the second part of dealing with psychiatry, Miranda Gill laments the absence of any attention paid to eccentricity in French historical accounts. Still on French literature of the same century, Michael Finn demonstrates the failed attempts at a medical reformulation of the popular understanding of strongly embedded historical concepts of possession and hypnosis. What was meant to be treated as narratives of scientific progress became inverted to public imaginations of fetish behaviours. Another attempt to demystify the march of biomedical progress in mental health is highlighted in the experience of the development of Hungarian psychiatry. Emese Lafferton concluded that late 19th-century Hungarian literature expressed fears of the functioning of asylums as institutions that reinforces rather than liberate existing repressive social structures.

Resounding the late Roy Porter's call for historians to view the patient's perspective and his role as an active social player instead of a passive object, Philip Reider, in the third part of the volume, focuses on the understanding of lay medical cultures through the accounts of 18th-century writers like Jean-Jacques Rousseau and Isabelle de Charriere. This is followed by Rousseau and David Boyd Hancock's contribution on the analysis of the English poet, Samuel Taylor Coleridge's rich but troubled and conflicting accounts of mapping symptoms of illness within his body, even none seemed to be found by doctors. To the authors, he personified the legacy of poetry, melancholy and hypochondriasis, or what is termed as 'diseased imagination'.

Finally, on the section concerning metaphors of diseases, Agnieszka Steczowicz explains the 16th-century terminology of 'paradox' to the difficulties of categorising new diseases through the vocabulary of existing medical traditions. Hence, the word promised controversy and departure from accepted norms, and embraces discovery and innovation. From her study of Victorian culture, Kristie Blair touches on matters of the heart in her chapter on the enduring cultural significance of the heart in spite of the pressures of the rising influences of biomedical ideas of it as a functional physical organ. Lastly, Stephan Besser draws light to Henry Wenden's colonial novel *Tropenköller* in 1904 as a text that circulates between different frames of politics, literature and medicine. The title, a compound of the German dialect of both 'tropics' and 'choleric', assumed the metaphor of the German contempt for, and its atrocities in, its African colonies in the early 20th century.

Overall, the organisation and quality of the contributions in the volume are pleasing, reflecting on both the commitments of individual authors and editors. This is demonstrated in the long discussions in the introductory chapter to the detailed elaboration of themes and events. Rousseau has even pre-empted critical reviewers by both acknowledging previous works on culture and medicine, and also apologising for the lack of a larger representation of topics and coverage on larger sociological themes. Nonetheless, questions remain about the ambiguous place of *Framing and Imagining Diseases* in the interdisciplinary framework that he eagerly embraces. Even as the academic focus of culture and medicine has been relatively recent, this publication is neither a novel project, nor is it tailored to break into new conceptual grounds. The aims of the authors in offering alternative interpretations by different frames to counteract the absolutist claims of modern biomedicine cannot be considered to be radical. On the contrary, it seems that the editors are more successful in attempting to institutionalise and reassert the dichotomy between the traditional Roserbergian and the 'newly established' Rousseauvian schools of thought. Last but not least, Rousseau has yet to reconcile the fact that, in spite of its claims of multidisciplinary, the field of culture and medicine has evolved into a distinct study, instead of one that could move freely between cultural studies, history and medicine.

George Sebastian Rousseau, with Miranda Gill, David Haycock and Malte Herwig (eds). *Framing and Imagining Disease in Cultural History* (New York: Palgrave, 2003) 329 pp.

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Wellcome Trust Centre for the History of Medicine at University College London

VISITORS AND EVENTS

Visitors to the Wellcome Trust Centre for the History of Medicine at University College from June through December 2004 have included:

Prof. Rima Apple* (University of Wisconsin-Madison), Science + Love.

Dr Luc Berlivet (CNRS-CERMES), The impact of the smoking/lung cancer controversy on the global setting of British biomedical research.

Dr Carmen Caballero (University of Granada), The Hebrew written production on women's healthcare.

Lucia Candelise (EHESS, Paris), Chinese medicine in France and Italy.

Dr Che-Chia Chang (Academia Sinica, Taiwan), Rhubarb as a medicine and Sino-British relations, via British Academy award.

Dr Michael Clark* (ex-Wellcome Library), Anglo-Irish medico-legal relations from the Act of Union to independence, and archival medical film and history.

Dr Esté Dvorjetski* (University of Haifa), Leisure, pleasure and therapy in Roman-Byzantine Palestine and Jordan.

Dr William Gallois* (American University of Sharjah/Mellon Fellow, SOAS), A history of medical ethics in Algeria and Morocco, 1800-2000.

Dr Debabrata Ghosh (All India Institute of Medical Sciences, New Delhi), Ideas and concepts about issues related to human fertility in pre-Mughal India.

Prof. Sander Gilman* (University of Illinois-Chicago), Vocabularies of good diagnostic practice.

Dr Geoff Hudson (McMaster University), The English military hospital, 1644-1790.

Dr David Israel* (BC's Children's Hospital, Vancouver), Medical specialisation in the second half of the 20th century.

Prof. Amarjit Kaur (University of New England on a British Academy Visiting Professorship), Migrant Indian labour in Malaya and Burma, 1880-1940: Workers' health and health services in plantation and industrial/urban sectors.

Dr Jennifer Keelan (Toronto), Late 19th century medical calculating and risk assessment.

Prof. Steven King (Oxford Brookes University), The sick poor.

Dr Shang-Jen Li (Academia Sinica, Taiwan), Healing bodies, saving souls: Medical missions to 19th-century China.

Dr Anita Magowska (Karol Marcinkowski University of Medical Sciences, Pozna, Poland), Charity and its impact on healthcare in the 20th century.

Prof. Janet McCalman (University of Melbourne), A social history of the underclass in Australia.

Prof. Ian McDonald* (formerly Harveian Librarian at the RCP), The views of central nervous system mechanisms held by clinicians and physiologists in the latter half of the 19th century and a history of the contributions of the National Hospital of Neurology, London in the second half of the 20th century.

Dr Arouna Ouedraogo (INRA, Paris/EHESS, Paris), The social history of vegetarianism.

Dr Christiane Sinding (CERMES/CNRS, Paris), A history of diabetes mellitus and insulin.

Dr Chris Waters (Williams College, Williamstown, MA), Psychiatry, the state and sexual selfhood in modern Britain.

Sally Bragg, Visitor and Programmes Administrator (apologies to those of our visitors whose plans were not finalised at the time of providing copy).

* Are at the Centre at the time of publication.

From 20 December 2004 the Centre's new address is 210 Euston Road, London NW1 2BE, UK

Centre for the History of Medicine at Birmingham

ROBERT ARNOTT

The Centre for the History of Medicine, a HEFCE-funded academic department within the Medical School of the University of Birmingham, was established in December 2000 to support and promote teaching and research in the history of medicine and help develop the rapidly expanding reputation in this field in one of the UK's top research universities.

The Centre, uniquely located in a medical school, continues to grow very quickly and is now looking at ways of developing its research potential.

TEACHING

Unlike many other similar centres, devoted exclusively to research and some limited postgraduate teaching, the principal core function of the Centre is to undertake its extensive programme of undergraduate teaching in the history of medicine and healthcare, mainly to students of medicine, dentistry and professions allied to medicine. The history of medicine has a significant place in a number of undergraduate degree programmes. For example, in the last five years, over 700 medical students have now studied the subject at different levels, from our continually expanding Intercollegiate BMedSc Degree in the History of Medicine. Our programme also admits a number of students from medical schools outside Birmingham, onto the six-week special study modules.

Outside the undergraduate sphere, the Centre is expanding its taught postgraduate degree programmes, which will be resourced from within the School and the Centre. These include a mixed taught/research MPhil (History of Medicine) degree programme, which is already running, an internationally unique MSc (History of Military Medicine and Healthcare) degree programme available from 2005 and organised in collaboration with the Royal Centre for Defence Medicine.

We are also looking at starting an MSc programme in disease and medicine in the ancient world within two years. Some modules that are associated with the intercalated degree are available to students from the School of Historical Studies and all of our modules since September 2004 are also available as continuing professional development (CPD) stand-alone courses, which will bring in considerable financial resources.

SEMINARS AND CONFERENCES

Regular fortnightly meetings of the Centre's History of Medicine and Health Research Seminar, which has an average attendance of 22, including both clinicians and historians, and a series of conferences and workshops supplement the research of the Centre.

Since the foundation of the Centre we have organised 15 conferences, many in conjunction with other bodies, such as the Society for the Social History of Medicine.

EXPANDING RESEARCH

Much of our work, located in a School where all the RAE scores are either 5* or 6* and where the history of medicine is a recognised research discipline, supports an active programme of research funded by a number of bodies including: the University itself, the University Hospital Birmingham Charities, the Wellcome Trust, the Institute for Aegean Prehistory, the Arts and Humanities Research Board and the Sir Arthur Thomson Charitable Trust. Part of the Centre's strategy is to consolidate and expand its principal research themes: (a) The history of medicine and healthcare in Birmingham and the Black Country, especially its voluntary hospitals; (b) medical education in provincial England, 1800–1948; and (c) ancient medicine and palaeodisease. In the latter research theme within the field of bioarchaeology, the Centre is now internationally recognised as having the lead in research in palaeodisease, health and medicine in the Bronze Age cultures of the Aegean and Anatolia. Members of the Centre are currently developing additional research foci, particularly the history of occupational health and medicine and the history of military medicine and healthcare. The staff, both core and other, produces a steady stream of books and articles, many as the result of our conferences and meetings.

The Centre brings together scholars not only within the School of Medicine (and the Royal Centre for Defence Medicine), but also on a collaborative basis with scholars from other different schools of the university, which touch upon the history of disease, medicine, nursing and historical demography. Internationally, the Centre now has very close links with the University of Salzburg in Austria, and Lund and Uppsala Universities in Sweden, with whom we are developing research links and student exchange programmes.

The Centre will be greatly enhanced with the imminent move of the Birmingham Medical Institute, founded in 1875, into the Medical School, which will lead to the creation of a substantial history of medicine library (The Sampson Gamgee Library in the History of Medicine).

As well as being a centre of excellence in the teaching of the history of medicine to medical undergraduate and postgraduate students, plenty of opportunities exist for postgraduate research students to undertake research based upon the Centre's research strengths and current projects. It is possible to work towards the degree of MPhil, MLitt and PhD by research, and for some clinicians, MD by research. By the autumn of 2004, the Centre had 14 postgraduate research students who have now forged themselves into a vibrant research and social community.

STAFF

Dr Jonathan Reinarz's Wellcome University Award, which will convert into a permanent Lectureship in the History of Medicine, and the appointment of Dr Anne Spurgeon as a part-time Senior Lecturer, have greatly strengthened the work of the Centre with the addition of modern medical historians on our core staff. They join the Director, Robert Arnott, recently promoted to Reader in the History of Medicine and leading specialist in palaeodisease and ancient medicine, and Hilary Morris, a Teaching Fellow who specialises in the social history of medicine from the 18th to the 20th centuries. Together with the support staff, many of whom undertake teaching as well as research, we have a superb base with which to continue our work and expands our activities.

THE FUTURE

At the Centre, we have a clear strategic plan and a number of objectives. They are based around the

consolidation of the Centre's existing research base in its key research areas, expanding the research capacity of existing staff by attracting major research grants in these areas and further permanent academic appointments. We aim to forge stronger interdisciplinary links within the university, especially with the School of Historical Studies. On the international front, we plan to develop existing international contacts and collaborative research.

Going back to our core activity, the development of research-led teaching, particularly in the field of taught postgraduate programmes and CPD, and the training of Master's and PhD students is of paramount importance. Finally, we hope to improve dissemination of our research and develop our public engagement activities.

Robert Arnott is a Reader in the History of Medicine, Sub-Dean of Medicine and Director of the Centre for the History of Medicine in the University of Birmingham Medical School (E R.G.Arnott@bham.ac.uk).

A historic day: Manchester Wellcome Unit's outreach event

JULIE ANDERSON, EMM BARNES, NEIL PEMBERTON AND DUNCAN WILSON

In March 2004 our first outreach event was held at the Eureka! Science Museum over two days. Organised by Dr Emm Barnes the days were organised to widen the exposure of history of science technology and medicine, and offered hands-on learning experience about disability both in the past and the present.

In describing reasons for planning and organising this particular event, Emm Barnes said, "We felt that the history of medicine was a great way to increase children's interest in science and technology. The stress on hands-on learning at Eureka enabled us to get away from more formalised learning environments and bring aspects of our work to life with real objects and personal experiences. Once children see the many ways in which human ingenuity has improved health and wellbeing over time, they see the point in learning more about science and may grow up to consider careers in science, technology and medicine".

The event was organised into three separate sections, 'Design Your Own Body Part', 'Communicating Without Sound' and 'Games Disabled People Play'. In 'Design Your Own Body Part', Julie Anderson made the history of medicine come alive for the participants with a combination of play-acting, demonstration and activities. As expected, the children intimated that history was dull and boring. Julie and Emm enacted a scene from the turn of the century: Emm, was the

patient and had her arm removed with an amputation kit and without the benefit of anaesthesia. This quickly altered the children's view that history of medicine was dull and boring! Different artificial limbs and internal prostheses were shown to the children, loaned kindly for the event by Dr Peter Mohr at the University of Manchester Medical School. The children tried to guess what all the prostheses were for and were encouraged to ask questions and touch the items that were on show.

In his session 'Games Disabled People Play', Duncan Wilson concentrated on sport for disabled people – with particular emphasis on the game of blind football. The children were initially incredulous when told that loss, or impairment, of sight was no barrier to participation in



Right:

Children at the Manchester Unit's first outreach event in March.

Image courtesy of authors

football. All believed that sight-impairment was totally restrictive in this respect. The aim of this session gave the children first-hand experience of the skills required to partake in these activities.

All participants were made aware of blind sports and the heightened skills required for participation. Some children expressed admiration for those who played in blind football, and clearly saw blindness as less limiting than they did initially.

In the workshop 'Communicating Without Sound' Neil Pemberton aimed to highlight the diversity of non-verbal communication. All children were given the opportunity to learn some basic sign language and create a sign name, as well as working with each other in a fun-based activity. By giving children first-hand experience of nonverbal communication, the activity sought to question any commonsense views children had of non-verbal communication.

Helen Barraclough for Eureka! said, "The Challenge Days were a huge success with the children and the teachers. The activities provided enrichment opportunities for the children to develop their problem-solving skills, whilst raising awareness of the challenges faced by people with disabilities. It was also a wonderful opportunity for



the children to meet real-life academics and be introduced to the possibilities of higher education."

First of these outreach events was a great success and the two days were fun and educational for both the participants and the group leaders.

Florence Nightingale remastered

Previously unknown recording of Florence Nightingale's famous speech, made in support of the Light Brigade Relief Fund, 30 July 1890.

In May 1890 a public scandal erupted when it was discovered that many veterans of the Charge of the Light Brigade were destitute. The Secretary for War stated in Parliament that he could not offer assistance and in response the *St James's Gazette* set up the Light Brigade Relief Fund.

Colonel Gouraud, Edison's representative in Britain, arranged to make three sound recordings to support the fund:

- Alfred Lloyd Tennyson reading *The Charge of the Light Brigade* on 15 May 1890.
- Martin Lanfried, trumpeter and veteran, sounding the charge as heard at Balaclava, on 2 August 1890.
- Florence Nightingale, delivering a message to the veterans, recorded on 30 July 1890 at her home on 10 South Street, Park Lane, London.

This original wax cylinder features two recordings made by Nightingale reading the same speech. The second reading was first produced commercially



in 1935 on a 78rpm disc but it did not feature her first attempt where she stumbles on her words and there is a long pause between the sentences. The wax cylinder is extremely fragile and each time it is played the recording becomes even more indistinct. The British Library Sound Archive technical team has now restored the recording and made it audible, using digital technology. The original will be preserved by the British Library, who have also featured it on their recently published *Voices of History* CD.

Top right:

Children playing a game of 'blind football'.

Image courtesy of authors

Right:

Florence Nightingale.

Calendar of events

TO ADD AN EVENT TO THE CALENDAR PAGE,
PLEASE SEND DETAILS TO THE EDITOR,
sanjoy.bhattacharya@ucl.ac.uk

JANUARY 2005

- 20 **History in Public Health seminar series:** Global biopolitics and world health
London School of Hygiene and Tropical Medicine, 12.45–14.00
Speaker: Alison Bashford (Sydney)
- 26 **Workshop:** Tuberculosis, migration and health screening: Comparative histories
London School of Hygiene and Tropical Medicine, 12.45–14.00
Speakers: John Welshman (Lancaster), Alison Bashford (Sydney), Richard Coker (LSHTM)

FEBRUARY 2005

- 17–19 **Health and History: International perspectives**
University of Auckland, New Zealand
Contact: Linda Bryder (E l.bryder@auckland.ac.nz)
- 24 **History in Public Health seminar series:** Christian witness through medical service: the American Mission Hospitals in Ceylon, 1850–1960
London School of Hygiene and Tropical Medicine, 12.45–14.00
Speaker: Margaret Jones (Oxford)

MARCH 2005

- 11 **UK History of Nursing Research Colloquium**
Green College, University of Oxford
Contact: Helen Sweet (E helen.sweet@wuhmo.ox.ac.uk)
- 21–23 **Health, Heredity and the Modern Home, 1850–2000**
Centre for Medical History, University of Exeter
Contact: Claire Keyte (E cfmh@exeter.ac.uk)

APRIL 2005

- 16–17 **Sex Education of the Young: A cultural history**
University of Durham
Contact: Lutz Sauerteig (E l.d.sauerteig@durham.ac.uk)

SEPTEMBER 2005

- 1–4 **21st Congress of the British Society for the History of Medicine**
Institute of Arab and Islamic Studies, University of Exeter
Contact: Claire Keyte (E cfmh@exeter.ac.uk)
- 7–10 **Cultural History of Health and Beyond.**
Joint conference of the Society for the Social History of Medicine and the European Association for the History of Medicine and Health
Ministère de la Recherche, Paris, France
Contact: Patrice Bordelais (E bordela@ehss.fr)

JUNE 2006

- 28–30 **Practices and Representations of Health: Historical perspectives**
Contact: Robert Arnott (E R.G.Arnott@bham.ac.uk)

APRIL 2007

- 18–21 **The History of Work, Environment and Health**
Contact: Robert Arnott (E R.G.Arnott@bham.ac.uk)

For a fuller listing of lectures, seminars, conferences and other events relating to the history of medicine, visit <http://medhist.ac.uk/events>

WellcomeHistory

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Preferably, contributions should be pasted into an email and sent to the editor (E sanjoy.bhattacharya@ucl.ac.uk).

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30 December 2004.

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